North East **LHIN**

North East Local Health Integration Network

Working For Northerners, Working With Northerners -- To ensure quality health care

2011/12 Annual Report

Ontario

Local Health Integration Network

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Cover Photos:

Left: Gordon, with the Alzheimer Society in Sudbury, is helpfully assisted by health care worker Pauline Fillion. **Top Right:** Rita Wemigwans, a happy client of the LHIN-funded mobile day program offered to Manitoulin Island communities. **Bottom Right:** Dorothy Lalic and Lucille Patry enjoy the greenhouse at the Parkside Older Adult centre in Sudbury.

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North East
Local Health Integration Network

HUB Planning Areas

This illustration depicts the North East LHIN's "HUB" planning areas. Planning areas have been determined by hospital referral patterns within the North East LHIN.

Message from the Board Chair and CEO

This 2011/12 Annual Report describes the North East LHIN's work to engage with fellow Northerners to improve access to care in Northeastern Ontario, where and when it's needed.

Wally Wiwchar, Vice Chair

Community engagement was a significant and productive focus of our time and energy throughout the year.

We appreciated and respected the numerous, helpful and thoughtful contributions made by hundreds of people -- both community members and health service providers. Our 2011 *Summary Report of the NE LHIN's Community Engagement Sessions* reflects the comments received on how health care is experienced and delivered in Northeastern Ontario.

Working within the fiscal reality of the time and the Ministry's Action Plan for Health Care (January 30, 2012), we held further engagements during February and March 2012 in our "HUB" areas of Cochrane and Temiskaming to initiate realignment efforts in the interest of enhanced patient care. Follow up work and engagements in these areas will continue in 2012.

Louise Paquette, CEO

The overall goal of all NE LHIN engagements is to ensure Northern voices are heard and reflected in building a local health care system that provides the right care, in the right place, at the right time, and at the right cost.

A few highlights of our 2011/2012 year achievements include:

- Success in working with health care partners and stakeholders in our Algoma "HUB" to establish a solid foundation for the Algoma Anchor Agency -- an integration of 13 mental health and addiction providers and more than 100 services. The Agency now has an inaugural Board of Directors and is moving forward.

- For the first time in many years, the rates of ALC patients in the region's four large hospitals' acute care beds decreased from highs of more than 25% to 11%. Much of the NE LHIN's effort to decrease rates has been with our four large urban hospitals given that they account for almost 70% of all ALC patient days across the region.

- 21,535 patients were served using Telemedicine (TM) across 207 sites in the NE LHIN, a 120% increase from 2010. The NE LHIN has 207 TM sites, and is the highest user of Telemedicine among Ontario's 14 LHINs.

- The Local Aboriginal Health Committee strengthened its Terms of Reference and continued to advise the NE LHIN and its Board of Directors on health service priorities

within Aboriginal (First Nation, Métis, urban, rural) communities and opportunities for the integration and coordination of health care services.

- The NE LHIN worked alongside the *Réseau du mieux-être francophone du Nord de l'Ontario* in engagement efforts and much progress has been made to advance French Language service designations across the region.

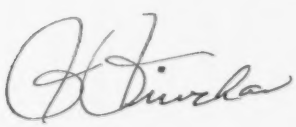
- A first-ever Chronic Disease Prevention and Management Workshop, bringing together more than 100 front-line care providers, was held in Sudbury in October.

- The last of five Joint Assessment Centre sites for the North East Hip and Knee Replacement Program was opened across the region. They are located at the North Bay Regional Health Centre, Sault Area Hospital, Health Sciences North in Sudbury, Timmins and District Hospital, and West Parry Sound Health Centre.

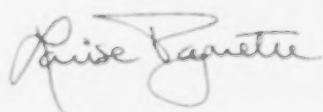
- Over 100 Telemedicine coordinators attended an Ontario Telemedicine Network Education Conference hosted by the North East and North West LHINs and OTN.

The outcome of our 2011/12 engagements, our IHSP priorities, and *Ontario's Action Plan for Health Care*, will continue to guide our efforts to lead integration and realignment activities and create a more patient-centred system of care for Northerners

Finally, we wish to add a note of remembrance regarding the late Randy Kapashesit, a long-time NE LHIN board member, and Interim Chair from June 2011 until his sudden death on April 25, 2012. Randy, from Moose Factory, worked extremely hard to make life a better place for people from all walks of life and communities. He always spoke with respect, candor and passion. We will remember him and his strong contribution to the work of the NE LHIN.



Wallace "Wally" Wiwchar
Vice Chair



Louise Paquette
Chief Executive Officer

NE LHIN Facts, Stats and Figures

- 550,000 people; 60% urban, 40% rural
- 17% aged 65+ (13% for Ontario); in 2030, 30% (compared to 22% for Ontario)
- 10% Aboriginal
- 24% Francophone
- 186 health service providers funded by the NE LHIN (25 hospitals, 42 long-term care homes, the North East Community Care Access Centre (CCAC), 48 community mental health and addictions providers, 71 community support services, six community health centres)
- 27 Family Health Teams and three Aboriginal Health Centres.
- A higher percentage of people living with chronic diseases than the rest of Ontario, including:
    - arthritis/rheumatism - 24% vs.17%;
    - asthma - 10% vs. 8%;
    - high blood pressure - 23% vs. 17%;
    - diabetes – at 7.2% vs. 6.4%; in fact, in some communities along the Hudson and James Bay Coast, more than half of the people live with diabetes;
    - The North East has declining demographics (total population down 5% since 1996), a dispersed population of 550,000 people across 400,000 square kilometres, and limited health care professionals to provide services. In addition to chronic diseases, the health profile of Northerners includes a long list of higher-than-provincial averages. It includes more people living with substance abuse, and more obesity.
- NE LHIN has 37 full-time staff located in community-based offices in North Bay, Sault Ste. Marie, Sudbury and Timmins.

Frank Laila takes time to enjoy the Northern spring sunshine in Sudbury.

NE LHIN Board of Directors

Our Board of Directors is an active Board with enthusiastic and hard-working members who bring a wide variety of expertise to the table.

Our Board members bring the face of the communities we serve to our governance table, and as we seek new board members, this wide breadth of skills and expertise will continue to be sought.

Wallace "Wally" Wiwchar
Timmins
Vice Chair
Term: Feb. 9, 2011 to Feb. 8, 2014

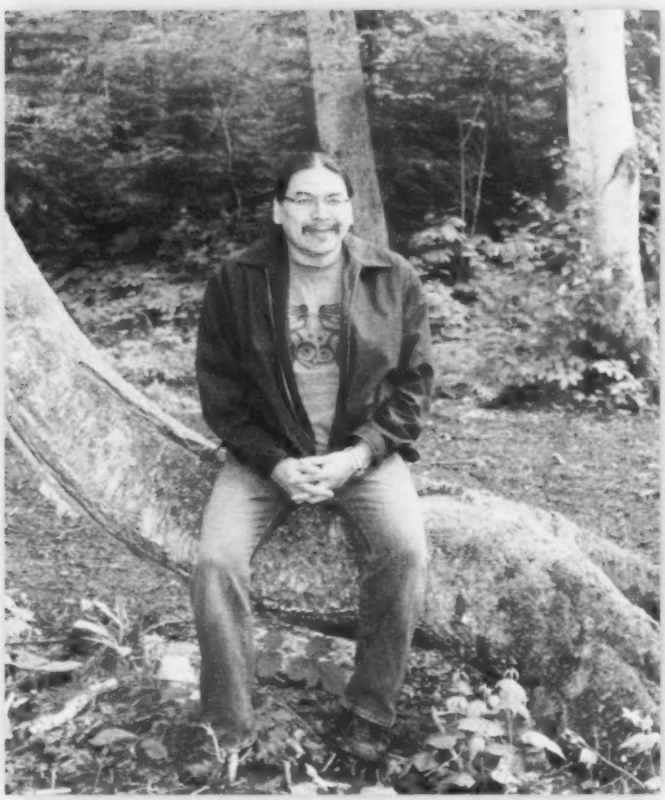
Cecilia Bruno
Sault Ste. Marie
Term: June 1, 2011 to May 31, 2014

Dr. Ian Cowan
North Bay
Term: Feb. 10, 2010 to Feb. 9, 2013

Dr. Colin Germond
Sudbury
Term: April 21, 2010 to April 20, 2013

Leah Welk
Parry Sound
Term: Sept. 24, 2008 to Sept. 22, 2012

Danielle Bélanger-Corbin
Temiskaming Shores
Term: Sept. 29, 2010 to Sept. 28, 2013



Randy Kapashesit, from Moose Factory, was a long time NE LHIN Board member. He began his term September 20, 2006. He served as Interim Chair from June 1, 2011 to April 25, 2012, when he passed away unexpectedly. He was a passionate individual who wore many hats including serving as Chief of the Mocreebec Council of the Cree Nation. An articulate, passionate speaker, he worked extremely hard to make life a better place for people of all walks of life and communities. He is dearly missed by many.

Ministry-LHIN Performance Agreement (MLPA)

The Ministry-LHIN Performance Agreement (MLPA) defines the relationship between the Ministry of Health and Long-Term Care (MOHLTC) and the NE LHIN in the delivery of local health care programs and services. The MLPA establishes a mutual understanding between the Ministry and the LHIN and outlines performance indicators within a defined period of time.

It is important to note that the final column of the chart below is an estimate at the time of printing given that full results for the final quarter of fiscal 2011/12 were not in. Preliminary results indicate a favourable change in several indicators due to full implementation of NE LHIN initiatives but could not be included at the time of printing. For an up-to-date status report on indicators, please contact the NE LHIN or visit www.nelhin.on.ca.

	Performance Indicator	LHIN 2011/12 Starting Point	LHIN 2011/12 Performance Target	Most Recent Quarter 2011/12 LHIN Performance	Percent from Target for Most Recent Quarter Result*	FY 2011/12 LHIN Annual Result
Emergency Room/Alternate Level of Care						
1	Percentage of Alternate Level of Care (ALC) Days - By LHIN of Institution***	33%	17%	25%	47.5%	32%
Good progress was made in 2011/12 with 27,000 ALC days removed from the system between Q1 and Q3. Emphasis was placed on expanding services for: Home First, Assisted Living, Integrated Discharge Planning, Assess and Restore Beds and increased community capacity to care for seniors and the frail elderly outside of hospital. These efforts will be continued in 2012/13 and increased with more supports for elderly patients with behavioural challenges, CCAC case managers in selected Family Health Teams, and a new LHIN mandate to plan for primary care.						
2	90th Percentile Emergency Room (ER) Length of Stay for Admitted (LOS) Patients	28	23.5	28	19%	27
ER LOS performance for admitted patients improved in 2011/12. 9 of 11 reporting sites maintained an ER LOS below 25 hours. High rates of ALC patients in Sudbury and Timmins hospitals at peak times contributed to an overall longer wait time reported.						
3	90th Percentile ER Length of Stay for Non-Admitted Complex (CTAS I-III) Patients	7	6.5	7	13%	7
ER LOS performance for high acuity non-admitted patients remained stable throughout the year. High acuity patients are those that fall between an assessment of a "CTAS" 1 to 3. High acuity refers to people presenting themselves to the ER for life threatening or urgent health care issues. 9 of 11 reporting sites maintained ER LOS below 7 hours. High ALC and ER admissions particularly in Sudbury contributed to an increase in wait times.						
4	90th Percentile ER Length of Stay for Non-Admitted Minor Uncomplicated (CTAS IV-V) Patients	4	4	4	10%	4
ER LOS performance for low-acuity non-admitted patients remained stable throughout the year. Low acuity patients are those that fall between an assessment of "CTAS" 4 to 5. Low acuity refers to people presenting themselves to the ER for non-urgent health care issues such as low grade fevers, removal of stitches, etc. 7 of 11 reporting sites maintained ER LOS below 4 hours.						

Surgical Wait Times						
5	90th Percentile Wait Times for Cancer Surgery	62	48	65	35%	61
Cancer surgery wait times remained relatively stable throughout 2011/12.						
6	90th Percentile Wait Times for Cardiac By-Pass Procedures	62	49	29	-41%	31
Performance improvement in wait times for cardiac by-pass procedures improved markedly in 2011/12 due to additional surgeon capacity and improvements in patient flow strategies at Health Sciences North in Sudbury.						
7	90th Percentile Wait Times for Cataract Surgery	125	125	159	27%	156
Wait times for cataract surgery increased in 2011/12 due to increased volumes (demand). Prior to year-end, the NE LHIN reallocated volumes to surgical sites and increased available capacity to help ease pressures.						
8	90th Percentile Wait Times for Hip Replacement	301	215	332	54%	306
Wait times for hip replacement increased modestly in 2011/12. All sites except Timmins met volumes (Timmins was unable to meet volumes due to limited number of available surgeons. The NE LHIN assigned additional volumes to help ease pressures in Q4.)						
9	90th Percentile Wait Times for Knee Replacement	426	300	367	22%	402
Wait times for knee replacement decreased in 2011/12. All sites except Timmins (surgical supply issue) met volumes and NE LHIN assigned additional volume in Q4. Improvement in wait times is dependent upon additional volumes for the NE LHIN and successful recruitment of surgeons (Timmins).						
Diagnostic Wait Times						
10	90th Percentile Wait Times for Diagnostic MRI Scan	105	80	75	-6%	106
Wait times for MRI improved in 2011/12 with the addition of North Bay's first MRI scanner in May 2011. It is expected that with an additional MRI in the NE LHIN, wait times will continue to improve, however, demand for MRI continues to increase as the diagnostic modality of choice by clinicians.						
11	90th Percentile Wait Times for Diagnostic CT Scan	33	33	27	-18%	29
Wait times for CT scans improved in 2011/12 and it is expected that wait times in the range of 28 to 30 days will continue in 2012/13.						
Excellent Care for All/Quality						
12	Readmission within 30 Days for Selected CMGs**	17%	14%	16%	14%	16%
Performance improved modestly. Initiatives in Sudbury, such as the Congestive Heart Failure Clinic and Care Transitions Unit are addressing this patient population and should have an impact on reducing readmissions to hospital. Case Managers in selected Family Health Teams will contribute to earlier identification and treatment for frail elderly care.						

Mental Health and Substance Abuse						
13	Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions**	19%	18%	18%	-0.3%	18%
Performance at Q4 met target. Initiatives implemented in Q4 2011/12 include: Addictions Counseling resource in the Health Sciences North ER, a Peer Support Councilor in North Bay Regional Health Centre ER, a Case Manager in the ER at Sault Area Hospital, and access to more hours for "safe" beds for detox patients in Timmins will continue to contribute to reducing unnecessary revisits to the ER in 2012/13.						
14	Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions**	30%	27%	30%	10%	26%
Performance at fiscal year-end was close to target. Initiatives implemented in Q4 2011/12 include: Addictions Counseling resource in the Health Sciences North ER, a Peer Support Counsellor in North Bay Regional Health Centre ER, a Case Manager in the ER at Sault Area Hospital, and access to more hours for "safe" beds for detox patients in Timmins will continue to contribute to reducing unnecessary revisits to the ER in 2012/13.						
Access to Community Care						
15	90th Percentile Wait Time for CCAC In-Home Services - Application from Community Setting to first CCAC Service (excluding case management)	73	66	61	-7%	56
Performance is below target for 2011/12. This trend is expected to continue into 2012/13 with emphasis on increasing community capacity across the region to care for people outside of hospital. The NE CCAC is implementing standardized practice guidelines for rehabilitation services (key area for performance improvement).						

* A negative percentage means the LHIN is below its target

** FY 2011/12 is based on most recent four quarters of data (Q3 2010/11 - Q2 2011/12) due to availability

*** FY 2011/12 is based on most recent four quarters of data (Q4 2010/11 - Q3 2011/12) due to availability

Report on MLPA Performance Indicators

It is important to state that the chart above shows performance estimates at the time of its preparation (May 2012). It does highlight several areas of patient wait time improvement, and on-target performance for the North East LHIN.

Success Stories: NE LHIN wait times for a number of procedures improved from the previous year – Cardiac By-Pass Procedures wait times were the second-lowest in the province, Diagnostic CT scan wait times were well below target, MRI wait times decreased, Knee Replacement wait times were improved through the opening and use of LHIN-funded Joint Assessment Centres.

Alternate Level of Care (ALC): Much progress was made in 2011/12 with 27,000 ALC days removed from the system between Q1 and Q3. The NE LHIN focused on the following to help bring down rates of ALC patients: Home First, Assisted Living, Integrated Discharge Planning, Assess and Restore beds. Efforts will continue in

2012/13 with supports for behavioural patients, case managers in selected family health teams, and work to further integrate primary care into NE LHIN planning.

Emergency Room (ER): ER length of stay (LOS) performance for admitted patients improved in 2011/12. Nine of 11 monitored sites maintained an ER LOS below 25 hours. High ALC patient numbers in Sudbury and Timmins in particular hindered patient flow and contributed to longer wait times. Continued vigilance on ALC in 2012/13 will improve wait time for admitted patients in the ER. ER LOS performance for high acuity non-admits remained stable throughout the year. Nine of 11 monitored sites maintained ER LOS below provincial target of 7 hours. High ALC and ER admissions particularly in Sudbury contributed to the lack of performance improvement in 2011/12. ER LOS performance for low-acuity non-admits remained stable throughout the year. Seven of 11 monitored sites maintained ER LOS below provincial target of 4 hours. Patient flow in Sudbury and Timmins ER(s) contributed to length of stay performance. Improved ALC and reduced ER admits particularly in Sudbury will result in improved ER LOS for low acuity non-admits in 2012/13. The NE LHIN is working closely with HSN and community partners to address ER LOS in Sudbury. It is anticipated that these efforts will reduce ER over-crowding enabling improved wait time performance.

Surgical Wait Times

Cancer Surgeries: Cancer surgery wait times remained relatively stable throughout 2011/12. New surgeons (urology, ENT) in Sault Ste. Marie, where previously none existed, resulted in wait times increasing in this community as previously, patients were sent out of town to receive the specialized care needed. Wait times for cancer surgery is identified as a high priority for break-through results in Sault Ste. Marie in 2012/13 and this will result in reduced wait times. It is expected that wait times in Sudbury will be reduced in 2012/13. The appointment of a physician-community engagement lead by the Regional Cancer Centre will assist in standardizing the prioritization of patients in the NE LHIN resulting in improved wait time performance.

Cardiac Surgeries: Performance improvement in wait times for cardiac by-pass procedures improved markedly in 2011/12 due to the addition of surgeon and patient flow alignment at Health Sciences North in Sudbury.

Cataract Surgeries: Wait times for cataract surgery increased in 2011/12 due to volume (demand). All surgical sites met volumes with additional capacity available. With a 10% reduction in cataract volumes for 2012/13, it is expected that wait times will increase. The NE LHIN has and will continue to advocate for additional cataract volumes from the MOHLTC.

Hip Replacements: Wait times for hip replacement increased modestly in 2011/12. All sites except Timmins (due to surgical supply issues) met volumes and the NE LHIN assigned additional volumes in Q4. Improvement in wait times is dependent upon additional volumes for the NE LHIN and successful recruitment of surgeons (Timmins). The NE LHIN has and will continue to advocate for additional hip replacement volumes from the MOHLTC. In 2011/12 the NE LHIN implemented five Joint Assessment Centres (JACs), one in each of the orthopaedic surgical centres. JACs provide patients with access to an Advanced Practice Physiotherapist who conducts comprehensive assessments and advises the surgeon on best course of care. In 2011/12, 1,500 patients were assessed and determined to be appropriate for conservative care thus avoiding surgery and freeing-up time for the surgeons to provide consultation for those patients assessed as appropriate for surgery. In addition, JACs have enabled patients to opt for the next available surgeon in the NE LHIN. In

2011/12, 477 patients opted to select the next available surgeon.

Knee Replacements: Wait times for knee replacement decreased in 2011/12. All sites except Timmins (surgical supply issues) met volumes and NE LHIN assigned additional volume in Q4. Improvement in wait times is dependent upon additional volumes for the NE LHIN and successful recruitment of surgeons (Timmins). The NE LHIN has and will continue to advocate for additional knee replacement volumes from the MOHLTC.

The implementation of Joint Assessment Centres (JACs), as described above (Hip Replacements), was also greatly beneficial for Northerners with knee concerns.

MRI Scans: Wait times for MRI improved in 2011/12 with the addition of North Bay's first MRI scanner in May 2011. By Q4 2011/12 the NE LHIN achieved its performance target of 80 days (actual wait time at Q4 = 75 DAYS). It is expected that current wait times of 75-80 days will be maintained in 2012/13. Some unfunded additional capacity is available in Sault Ste. Marie, Timmins and North Bay. Demand for MRI continues to increase as the diagnostic modality of choice by clinicians.

CT Scans: Wait times for CT scans improved in 2011/12 and it is expected that wait times in the range of 28 to 30 days will continue in 2012/13.

Excellent Care for All/Quality:
Performance improved modestly. Initiatives in Sudbury including the Care Transitions Unit are addressing CHF and COPD patient population and should have an impact on reducing readmissions to hospital. Case Managers in selected family health teams will contribute to earlier identification and treatment planning for the frail elderly.

Mental Health/Substance Abuse:
Performance for Mental Health revisits to the ER at Q4 met target. Performance for Substance Abuse revisits to the ER met target overall for the fiscal year. Initiatives implemented in Q4 2011/12 including: addictions support in the ER (Sudbury), peer support in the ER (North Bay), case management in the ER (Sault Ste. Marie), access to more hours for "safe" beds (Timmins) and a Regional "Warm-Line" implementation will contribute to reducing unnecessary revisits to the ER in 2012/13. In addition, a community crisis centre in downtown (Sudbury) Q1 2012/13 will allow the diversion of people in crisis from the ER.

Access to Community Care: Performance was below target for 2011/12 and will continue into 2012/13; however, the emphasis on supporting ALC in hospital places pressure on CCAC to meet community targets. The NE CCAC is implementing standardized practice guidelines for rehabilitation services – a key area for performance improvement. A shortage of rehabilitation professionals in small communities contributes to longer wait times.

Community Engagement

The NE LHIN is accountable to the public's contributions through the organization's *Annual Communications and Community Engagement Plan.* The plan outlines how the NE LHIN will:

- Engage with its stakeholders and members of the public and connect their efforts to NE LHIN decision making.
- Enhance awareness of health care issues across Northeastern Ontario communities through mutual information sharing.
- Identify discussion items of mutual concern or interest.
- Evaluate the effectiveness of community engagement activities.

While this plan provides a structure for ensuring community engagement components in the work of the NE LHIN, it also provides flexibility to welcome and incorporate community engagement opportunities that arise over the course of the year. In 2011/12, the NE LHIN held extensive engagement sessions with thousands of Northerners. The information gathered during the year directly contributed to the LHIN's areas of focus for 2012, and is shared in the content of the LHIN's first-ever Report to Our Communities 2012.

This annual plan is complemented by the LHIN's use of the Physician Community Engagement Toolkit that is posted to our community engagement web page. The NE LHIN's Primary Care Lead will be instrumental in developing primary care engagements and integrations within 2012/2013. In addition, the LHIN will continue to work collaboratively with the Ontario Medical Association (OMA) to distribute relevant project-specific materials to primary care providers.

Engagement efforts held in the last quarter of 2012 also incorporated the need for system transformation as outlined in Ontario's Action Plan for Health Care.

Community Engagement with our Aboriginal/First Nation/Métis People

The NE LHIN Board of Directors is committed to an engagement process with its Aboriginal/First Nations/Métis communities and health service providers. The engagement process is respectful of language, nationhood, culture and spiritual beliefs.

Engagement with Aboriginal communities and health service providers occurs on an ongoing basis across the region. The NE LHIN focuses on capacity building and sustainability of current health services that will lead to better outcomes of the health status of this population group.

The NE LHIN Aboriginal/First Nation/Métis team focused on three key regional community engagements in 2011/2012:

- **Local Aboriginal Health Committee** – The members of the LAHC met for a full day face to face meeting in Sudbury with the Aboriginal/First Nation/Métis team, the NE LHIN CEO and Chair of the Board of Directors. The LAHC is made up of representatives from each of the NE LHIN's HUB planning areas. The engagement focused on planning priorities for First Nation communities within the current fiscal.

- **Community Support Services Common Assessment** – In November 2011, the NE LHIN and Aboriginal health service providers participated in a two-day event to support the implementation of the InterRAI CHA and the Integrated Assessment Record (IAR).

- **HSIF Information Session** – The NE LHIN Aboriginal team attended the Health Services Integration Fund (HSIF) Information Sessions held in Toronto and Thunder Bay offered by the federal government in partnership with the province. The session allowed for preliminary integration discussions among First Nation, provincial and federal partners.

Participants gained a deeper understanding of the assessment tool and provided feedback and cultural context with respect to the application of this tool in both the CSS sector and First Nation communities.

Based on the recommendations of an OCAN Aboriginal Working Group, an Aboriginal Support Validation committee was established in 2011 to evaluate and determine the cultural appropriateness of OCAN within Aboriginal populations. The OCAN Aboriginal specific activities include: training materials, such as case studies; training binders; consumer pamphlets; an Aboriginal Education Specialist to deliver training and support; and an Aboriginal Subject Matter Expert to address questions pertaining to Aboriginal landscape and issues. The validation project concluded in March 2012 and the OCAN Aboriginal Working Group is currently working on its final report and recommendations.

Maude Tyrer and Louise Paquette, CEO of the NE LHIN, talk about health care at the Elders Gathering Place in Moosonee.

Community Engagement with our Francophone Population

The NE LHIN developed a joint action plan for 2011/2012 with the French Language Health Planning Entity (the Entity) – the Réseau du mieux-être francophone du Nord de l'Ontario. An operational working group, comprised of the LHIN's French Language Services (FLS) coordinators and the Réseau's planning officers, was formed to collaborate on community engagement activities and initiatives, and action plan priorities.

At the end of 2011, the Entity submitted its first Advisory Report to the NE LHIN. This included a Community Engagement Plan. As per the funding and accountability agreement between the Réseau and the NE and NW LHINs, a Liaison Committee was established, with all three organizations represented at the senior level.

In 2011/2012, the Entity participated in community engagement activities hosted by the NE LHIN including one for the mental health sector in Algoma. In February/March 2012, the Entity actively participated in realignment engagements held in the Cochrane and Temiskaming Hub areas.

The Entity established "Carrefours santé" or "health tables" across the North East to help it gather input from Francophones regarding the local health care system and to better engage the Francophone community as a whole.

Seniors Yvette Plante, Aline Seguin, Denise Bundy and Gery Berthelot play cards at the Centre de santé communautaire du Grand Sudbury.

Integrated Health Service Plan (IHSP) – Meeting Local and Provincial Priorities

Alternate Level of Care Strategies and Solutions (ALC)

ALC patients are people in hospital beds who would be better cared for in an alternate setting such as long-term care, rehabilitation, assisted living or home. Having more home care and community services enables ALC patients to leave hospital sooner, making more beds available to patients who are waiting to be admitted to hospital.

In recent years, the NE LHIN continued to have the highest level of ALC in the province, but a clear change in the trend is appearing. From a high of nearly 41% of acute care days being ALC in the last quarter of 2010/11, the NE LHIN has seen this rate decrease to 25% in the third quarter of 2011/12 (note – the days are accumulated based on discharge patients). The NE LHIN's weekly internal monitoring of actual ALC patients in acute care beds places the rate closer to 17% for all 24 general hospitals in the region - which is the LHIN's performance target for this measure. The four large HUB hospital centres together averaged about 10% of ALC patients in acute care beds in 2011/12.

Amanda Deforge works with client Ermida Rossi at the Alzheimer Society Sudbury-Manitoulin's Adult Day program. Through the North East LHIN's Behavioural Support Action Plan, Alzheimer societies in Timmins, Sault Ste. Marie, North Bay and Sudbury have each received funding to hire a new Responsive Behaviour Facilitator.

Highlights of 2011/12 ALC activities in the North East include:

- A visit to the region by Dr. David Walker and his Provincial ALC Action Team in June to meet with a range of hospital and community providers to review and improve our approach to ALC.
- The development and implementation of a new ALC leadership and accountability structure in the North East that will ensure consistency in approach, strategy, priorities and outcomes across the region on major ED/ALC initiatives.
- Investments in the implementation or expansion of best practice programs to alleviate ALC pressures:

- Home First / Integrated Discharge Planning and community support services navigator positions in the four HUB hospital communities
- Providing resources across the region to support long-term care home residents with behavioural needs
- New Assess / Restore programs in North Bay and Timmins
- Additional seniors' assisted living capacity and enhanced CCAC in-home services
- Deploying CCAC case managers in emergency departments and family health teams
- Rolling out telehomecare to help care for people outside of hospital through technology
- Transitional care capacity to safeguard acute care services

The NE LHIN has been steadfast in its approach that no one organization or individual will solve the long-standing and complex issue of ALC. In 2011/12, the NE LHIN continued to work in partnership with health service providers and community leaders with the collective goal of fewer ALC patients in our hospital beds, seniors receiving the care they need in the most appropriate setting, and more home care services.

Emergency Department (ED) Wait Times

Throughout 2011/12, ED wait times in the North East, for both non-admitted complex and non-admitted minor/uncomplicated ED cases, were at or near the LHIN's target for these indicators (i.e. 90% of cases discharged within 6.5 and 4 hours respectively). The challenge in some communities remains the wait time for patients admitted from the ED to reach an inpatient bed – over 24 hours in certain cases. The region's four large hospitals participated in the provincial ED Pay for Results program in 2011/12 which helped them implement innovative programs targeted at improving ED performance. Examples include a short stay unit in Sudbury, clinical decision unit in Sault Ste. Marie, and inpatient admission nurses / patient navigators in North Bay and Timmins. More work to bring down wait times, particularly at Health Sciences North in Sudbury, will continue in 2012-13.

Aboriginal/First Nation/Métis Health Services

From the NE LHIN governance to senior management and staffing, Aboriginal / First Nations / Métis participation and guidance is entrenched within the NE LHIN organizational structure. One Senior Director and two full time Aboriginal officers manage the planning, funding and integration activities within the Aboriginal portfolio.

The NE LHIN's Local Aboriginal Health Committee (LAHC) advises the NE LHIN Board of Directors on health service priorities and opportunities for integration within Aboriginal, First Nation, Métis, urban and rural communities.

The Health Status and Environmental Scan for Aboriginal / First Nations / Métis people in Northeastern Ontario, completed in March 2011, is a valuable information tool that guides the planning activities of the LAHC.

The NE LHIN's Health Professional Advisory Committee appointed two Aboriginal members during the year. These new members represent different health professions, health sectors and geographical areas in the NE LHIN and provide advice to support the work of the NE LHIN Board, the NE LHIN staff as well as the members of the LAHC.

The LAHC meets a minimum of four times a year. In November 2011, a full day of community engagement was held to discuss health priorities and future activities of the LAHC. LAHC members reviewed the NE LHIN Mental Health and Addictions Framework and selected four priorities for action in 2012-13:

- To create seamless, integrated Aboriginal mental health and addictions services. In order to achieve this, service integration must be improved in areas of Traditional Aboriginal healing, mental health and addictions, primary care, provincial and federal services, and Aboriginal and mainstream service organizations.

- To improve integration of Traditional Aboriginal and clinical approaches. Mechanisms to support integration of traditional and clinical approaches will be encouraged, supported and designed as appropriate and in partnership with Aboriginal communities and service organizations.

LHIN CEO, Louise Paquette, speaks with Margaret Wabano, 108, and Cree translator Greg Spence in Moose Factory, February, 2012. Margaret was about to be discharged from hospital and, like most Northeastern seniors, was looking forward to going home. She was also looking forward to spending time with her friends at the Elders Gathering Place.

- To enhance knowledge exchange and access to information through the development of an agenda for Aboriginal, First Nations and Métis health information and data, extracting information from existing data sets to develop new databases and data sharing agreements.

- To support the development of appropriate planning mechanisms by establishing a NE LHIN Aboriginal Mental Health and Addictions planning table. Its focus will be to create and monitor systems and service integration of Aboriginal mental health and addiction services across Northeastern Ontario.

French Language Health Services – An Integrated Approach

The NE LHIN currently has 36 health service providers (HSPs) officially designated under the *French Language Services Act*, and has identified 68 other HSPs to work towards the implementation of FLS.

In 2011/2012, the NE LHIN accepted and approved requests for designation under the FLS Act from three HSPs in the community health sector. These requests are currently being processed by the Ministry of Health and Long-Term Care. The NE LHIN FLS staff are also providing guidance to four other HSPs who are currently working on designation plans.

In order to help ensure and monitor continuous improvement in the quality, accessibility and integration of FLS, the FLS accountability process was refined. Currently, 104 HSPs have a FLS performance indicator in their 2011-2014 multi-sectoral service accountability agreements.

The NE LHIN FLS staff members continue to work with the five bilingual and Francophone Community Health Centres (CHCs) to implement a joint action plan and address challenges and opportunities in the sector, with a focus on integration. This plan will lead to increased access to the primary health care sector for Francophones and will build on future initiatives with the new Primary Care Lead for the North East LHIN. The CHCs have expressed a keen interest in being active participants in primary care reform in Northeastern Ontario.

Addiction and Mental Health Services

The NE LHIN has implemented a number of "diversion" initiatives aimed at decreasing mental health and addictions consumer revisits to hospital emergency departments (ED). These initiatives include:

- Funding a new addictions case manager and community addictions service provider in the Sudbury ED to assist staff to assess and redirect consumers.
- Funding a mental health consumers agency to place "peer" support workers in the ED at North Bay Regional Health Centre.
- Funding a safe bed at the Jubilee Centre in Timmins to take pressure off the Timmins and District Hospital ED.
- Funding a mental health case manager at Algoma Public Health to work out of the Sault Area Hospital ED.

The NE LHIN funded the establishment of a regional "Warm Line" that provides consumer-led support to people in distress who reach out for support and assurance. The "Warm Line" operates with mental health consumers in Sault Ste. Marie, Timmins, Sudbury, North Bay and Parry Sound.

The NE LHIN has worked with CCIM to implement the OCAN & IAR in all mental health service providers across the region.

During 2011/2012, the NE LHIN continued to work with the Ministry of Children and Youth Services, North Bay Regional Health Centre and community children's mental health services to move towards a more decentralized model of children's mental health tertiary care. This initiative continues to evolve and it is anticipated that the beds will be decentralized by March 2013.

The NE LHIN is working with Health Sciences North and the Sudbury chapter of the Canadian Mental Health Agency to implement a centralized crisis service in the downtown core of the city of Greater Sudbury. This initiative will divert consumers in crisis away from the hospital and will decrease the time police need to wait with mental health people in distress before the disposition is completed. Funding was provided to CMHA Sudbury to hire two new crisis workers to work closely with hospital crisis staff.

The NE LHIN is working with the NE CCAC to hire 18 nurses to provided support to children in 11 district school boards across the North East.

The NE LHIN continues to work with small hospitals to identify processes that will improve the provision of psychiatric consultations and access to schedule-one hospital inpatient mental health beds when appropriate. The NE LHIN is in the process of determining if a "bed registry" with CritiCall is feasible and useful in this case.

The Algoma Anchor Agency (integration of 13 addiction and mental health service providers) is proceeding well with an inaugural board of directors and a charter. In March 2012 the agency hired its first staff, and it has established a location in Sault Ste. Marie.

The North East LHIN's new Regional Mental Health and Addiction Consultation Group.

A Regional Mental Health and Addiction Consultation Group was formed and met for the first time in May, 2012. The Group members has members from across Northeastern Ontario and will advise the NE LHIN on the implementation of the province's 10-year strategy *Open Minds, Healthy Minds*, and on important regional mental health and addiction issues.

Diabetes Strategy

Through its membership with the Diabetes Regional Coordination Centre, the NE LHIN continues to provide its expertise and resources to help diabetes health service providers acquire resources to support the integration of best practices.

In April 2011, the Ministry of Health and Long-Term Care, as part of the Ontario Diabetes Strategy, established Centres for Complex Diabetes Care (CCDC) to address the needs of individuals with diabetes who have complex health requirements. In the North East, Health Sciences North was the successful applicant for the regional program. Since April, the program has provided 161 active patients from Northeastern Ontario with assistance in acquiring comprehensive diabetes service. The CCDC program continues to work with community partners and the NE LHIN to provide patients with a more coordinated approach to their diabetes care.

On October 14, 2011, the NE LHIN held the first regionally focused Chronic Disease Prevention and Management (CDPM) workshop. The event provided an overview of CDPM related programs, identified both access and gaps to services, and identified related priorities. The session targeted health planners, hospitals, family health teams, health service providers, community health centres, and chronic disease-related organizations in the NE LHIN.

The workshop was attended by 95 health service providers. A follow-up workshop is scheduled for October of 2012 which will also include a First Nation and a Francophone CDPM component.

The NE LHIN is creating a CDPM inventory that will assist health service providers and their clients better identify chronic disease services as well as best practice models used by different chronic disease programs.

In the past year, Health Sciences North Self-Management Program has provided 65 individuals at risk of developing diabetes from Sudbury, Sheguindah, Sturgeon Falls, Massey and Elliot Lake with Self-Management Training. It has also trained 125 Health Service Providers and provided mentoring support to 22 providers from Sudbury, Sault Ste Marie, New Liskeard and Kirkland Lake. This year, 11 more activities are planned, including engagement with First Nation communities and workplaces on self-management workshops.

Health Human Resources

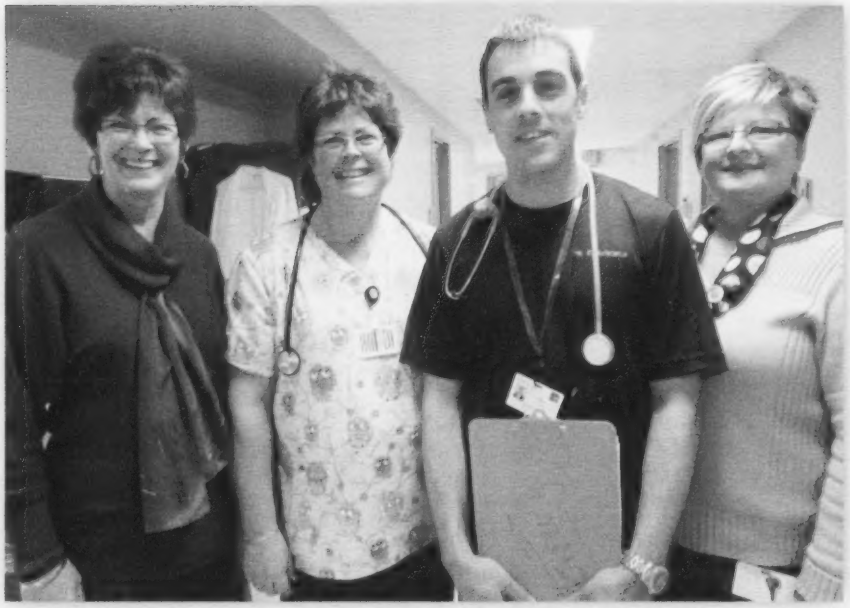
The lack of community support services, the need for increased integration and the importance of recruitment and retention of our human resources emerged in the 12 leading themes in the NE LHIN's extensive community engagement sessions in 2011.

The NE LHIN's Health Human Resources (HHR) Planning Steering Committee has identified key directions that call for increased collaboration:

- Shared recruitment services / career promotion
- Workforce Planning / Sustainability
    - HHR Inventory / Forecasting / Scheduling / Human Resources Information System
    - Partnerships with other stakeholders
    - Succession Planning / Shared functions
- Virtual "HR Department"
- Leveraging HealthForceOntario Marketing and Recruitment Agency.

The NE LHIN is facilitating the implementation of the *Action Plan on Enhancing the Personal Support Occupations Workforce (2011)*. The Action Plan details seven strategy areas which call for increased partnerships and innovation. These strategies include a need to formalize a process to define the gaps in workforce training; developing a business case for an awareness campaign on the role and importance of the personal support workforce; and partnership opportunities among health service providers.

The size of the NE LHIN health care workforce is estimated to be 12,300 full-time equivalencies (FTE). This figure does not take into account the contracted workforce through the many service providers contracted by the CCAC or the many physicians in private practice settings.



Louise Paquette (left), CEO of the North East LHIN, visits with Nurse Brenda Tabondonding, GEM Nurse Nelson Jay, and Charge Nurse Patti Farris, at the West Parry Sound Health Centre.

The NE LHIN launched an HHR Inventory Snapshot Tool to gain deeper insight into the workforce vacancies and projections. Currently, over 90 organizations are participating in the inventory and it is being used to support collaborative HHR planning across the region.

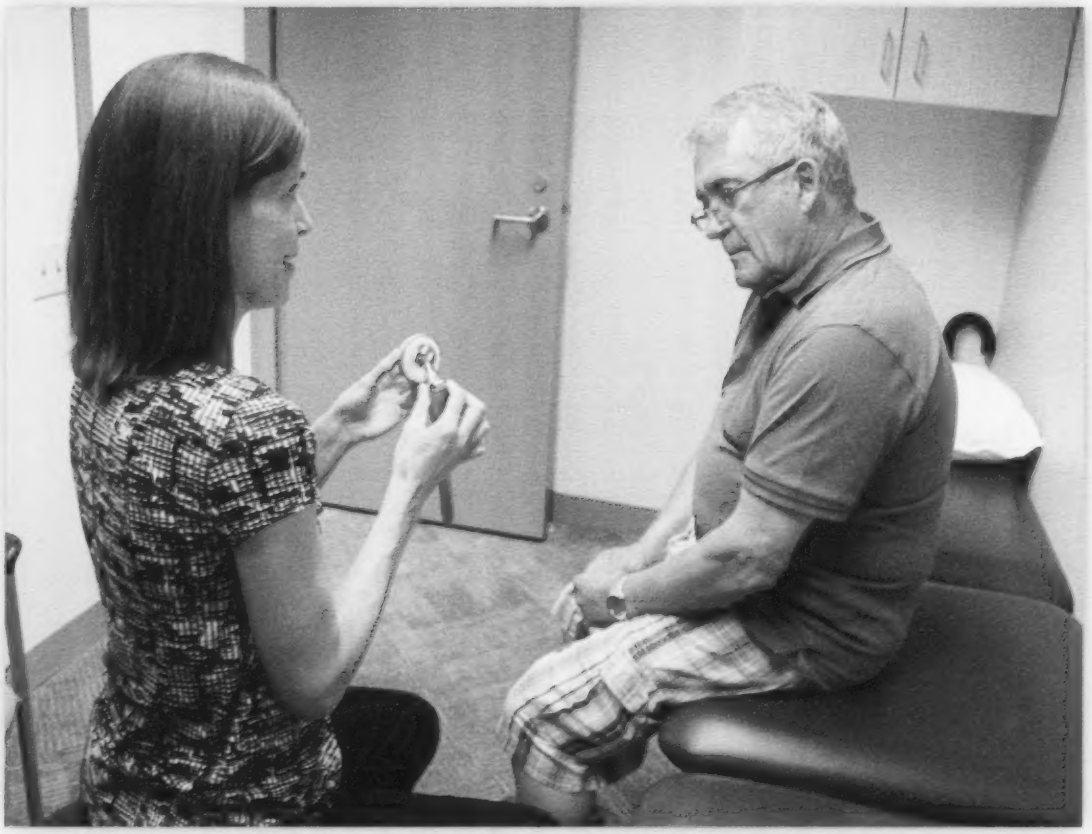
Optimize Surgical Services

The Surgical Optimization Steering Committee met on four occasions this past year and focused their attention on the following projects:

Hip and Knees
The five Joint Assessment Centres (JACs) located at Health Sciences North, North Bay Regional Health Centre, Sault Area Hospital, Timmins and District Hospital, and West Parry Sound Health Centre are fully operational. The centres were able to implement a web-based referral tracking system to better coordinate referrals and collect the required data for reporting requirements.

Call Schedule Project
Work is ongoing on the development of a call schedule for the specialists in the North East. Three main components have been identified as being essential for full implementation: identification of gaps in coverage by specialty areas; need for a web-based scheduler that can be adopted by the NE LHIN hospitals; and the need for on-call standards across the North East.

General Surgery Project
This project is being led by Notre Dame Hospital in Hearst and consists of the development of a model to ensure viability of general surgery across the region. In order to facilitate model development, the focus has been on the Cochrane Hub, with the goal of expanding across the North East in the coming year. To date, the project leads have met with the Cochrane Hub hospitals that provide general surgery, and the surgeons, to gather and validate the surgical data. This information consists of exploring opportunities of consolidating general surgery activities based on volumes, clarification of the role of small hospitals, on-call standards and recruitment opportunities. The hospitals and the surgeons provided feedback on how they perceive the model should unfold in the Cochrane Hub. Work is ongoing on this project, with future meetings taking place to confirm a model and move forward with implementation.



Tonia Cockburn, Advanced Practice Physiotherapist based at the Joint Assessment Centre in the North Bay Regional Health Centre, with patient George Lefebrve of Latchford.

NE LHIN Integration Activities

The NE LHIN continues to focus on integration initiatives that demonstrate action, priority setting and coordinated health service planning. In 2012, the following integration activities took place:

- Extensive engagement sessions in the District of Temiskaming to ensure increased collaboration among health service providers in the communities of Englehart, New Liskeard and Kirkland Lake. A realignment plan will be presented to the NE LHIN Board of Directors in June 2012.
- Extensive engagement sessions in Cochrane HUB communities to ensure increased collaboration among health service providers. A realignment plan will be presented to the NE LHIN Board of Directors in June 2012.
- Mental health and addiction service providers in the District of Cochrane continue work with the NE LHIN on a collaboration agreement to adopt a model for the integration of mental health and addiction services.
- Algoma Anchor Agency, which currently includes 13 mental health and addiction providers and one schedule-one hospital, reached another milestone with the appointment of an inaugural Board of Directors. Only those services that are funded by the NE LHIN's community mental health funding are within the scope of this project, impacting more than 100 services. The Anchor Agency will be centrally located in Sault Ste. Marie, with a satellite office in both North and East Algoma.
- The integration of Thessalon and Matthew Memorial Hospital (MMH) to Blind River District Health Centre (BRDHC) has been approved in principle by Sault Area Hospital (SAH) and BRDHC boards. Details of this integration are being reviewed by a SAH Integration Working Group and final recommendations will be brought to the NE LHIN in the 2012 fiscal year.

Engagement in action – Iroquois Falls, February, 2012, Cochrane realignment engagements.

Analysis of LHIN Operational Performance

The NE LHIN ended the 2011/12 year with a balanced position. Offices in North Bay, Sault Ste. Marie, Sudbury and Timmins have enabled LHIN staff to connect more frequently with health service providers and fellow Northerners throughout the year.

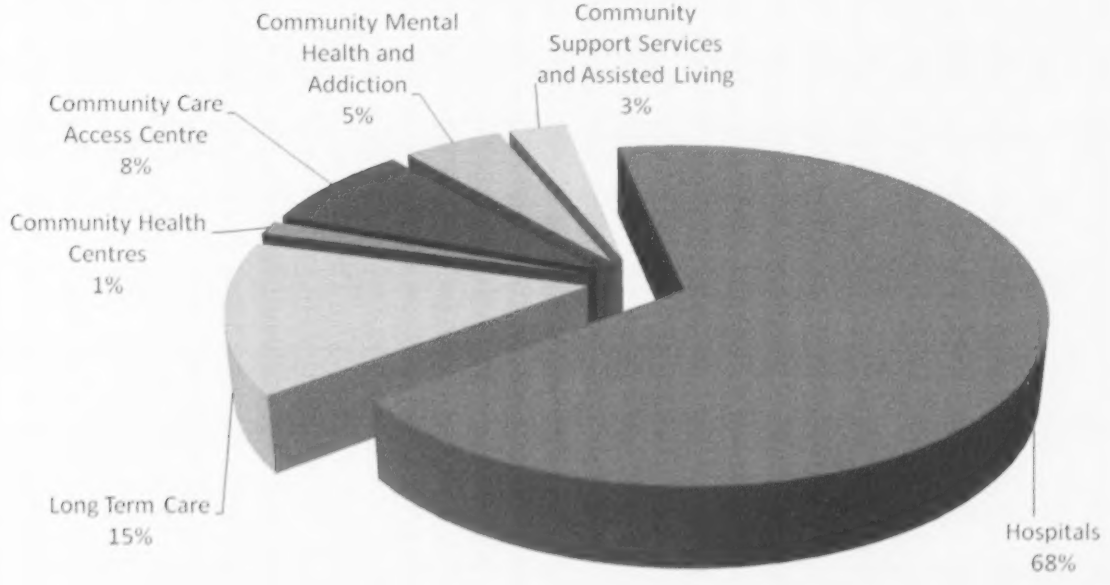
Through extensive community engagement efforts, our 37 staff were able to gather information that allowed the LHIN to direct funding to projects that would improve patient care and a more integrated and efficient delivery of services for people. Engagements also helped to identify priorities for 2012/13 and respond to the health care needs of fellow Northerners.

Our NE LHIN has established three physician leads with a focus on critical care, emergency departments and primary care. Their contribution and insight are assisting the NE LHIN in making decisions to improve the quality of care and enhanced access to care for Northerners.

Enhancing care beyond the walls of the hospital remains a top priority for our LHIN as we continue to address the alternate level of care issue in many of our communities. The NE LHIN has been successful in reducing the ALC rates from a high of close to 41% of acute care days being ALC in the last quarter 2010/11 to 25% in the third quarter of 2011/12 (note – the days are accumulated based on discharged patients).

Our first regional Chronic Disease Forum was held and highlighted the need for continued work on improving the health status across our LHIN and connecting with primary care to prevent progress of these diseases. A second forum will be held in the fall of 2012.

In 2011/12, the North East LHIN invested $1.4 billion in local health care programs and services.


Community Mental Health and Addiction 5%
Community Support Services and Assisted Living 3%
Community Care Access Centre 8%
Community Health Centres 1%
Long Term Care 15%
Hospitals 68%

Financial statements of

North East Local Health Integration Network

March 31, 2012

North East Local Health Integration Network

March 31, 2012

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Independent Auditor's Report

To the Members of the Board of Directors of the
North East Local Health Integration Network

We have audited the accompanying financial statements of the North East Local Health Integration Network (the "LHIN"), which comprise the statement of financial position as at March 31, 2012, and the statements of financial activities, changes in net debt and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with Canadian public sector accounting standards and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements present fairly, in all material respects, the financial position of LHIN as at March 31, 2012, and the results of its financial activities, change in its net debt and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

Deloitte & Touche LLP

Chartered Accountants
Licensed Public Accountants
June 12, 2012

North East Local Health Integration Network

Statement of financial position
as at March 31, 2012

	2012	2011
	$	$
Financial assets		
Cash	**360,696**	813,944
Due from the LHIN Shared Services Office (Note 3)	**466**	1,632
Accounts receivable	**16,431**	67,719
HST Receivable	**39,867**	109,806
Due from MOHLTC-Health Service Providers ("HSP") (Note 7)	**7,992,935**	20,697,997
	8,410,395	21,691,098
Liabilities		
Accounts payable and accrued liabilities	**358,087**	633,563
Due to MOHLTC & eHealth Ontario(10b, 10c)	**76,904**	360,216
Due to Health Service Providers ("HSP") (Note 7)	**7,992,935**	20,697,997
Deferred capital contributions (Note 4)	**165,466**	226,144
	8,593,392	21,917,920
Commitments (Note 13)		
Net debt	**(182,997)**	(226,822)
Non-financial assets		
Prepaid expenses	**17,531**	678
Capital assets (Note 5)	**165,466**	226,144
	182,997	226,822
Accumulated surplus	**-**	-

Approved by the Board

Director

Director

North East Local Health Integration Network

Statement of financial activities
year ended March 31, 2012

	Budget (Unaudited) (Note 6)	2012 Actual	2011 Actual
	$	$	$
Revenues			
MOHLTC funding			
HSP transfer payments (Note 7)	**1,305,521,545**	**1,380,862,148**	1,334,539,486
Operations of LHIN	**5,002,882**	**5,002,882**	4,919,443
e-Health (Note 9a)	-	**600,000**	600,000
e-Health Project Funding	-	-	110,000
Behavioural Support Ontario (Note 9b)	-	**72,000**	-
French Language Health Service (Note 9c)	**296,800**	**296,800**	209,900
Francophone Community Engagement	-	-	186,400
Réseau du mieux-être francophone du Nord de l'Ontario (Note 9d)	**796,159**	**802,973**	229,040
Emergency Department Lead (Note 9e)	-	**75,000**	75,000
Critical Care Lead (Note 9f)	-	**75,000**	75,000
Aboriginal Engagement (Note 9g)	**100,000**	**100,000**	100,000
Aboriginal Health Transfer Fund	-	-	146,590
Emergency Room/Alternate Level of Care (Note 9h)	-	**100,000**	100,000
Primary Care Lead (Note 9i)	-	**43,750**	-
Amortization of deferred capital contributions (Note 4)	**60,676**	**60,678**	72,485
	1,311,778,062	**1,388,091,231**	1,341,363,344
In year surplus recovered by MOHLTC (Note 10)	-	**(31,750)**	-
Funding repayable to MOHLTC and eHealth Ontario (Note 10)	-	**(76,904)**	(360,216)
	1,311,778,062	**1,387,982,577**	1,341,003,128
Expenses			
Transfer payments to HSPs (Note 7)	**1,305,521,545**	**1,380,862,148**	1,334,539,486
General and administrative (Note 8)	**5,002,882**	**5,002,882**	4,706,974
e-Health (Note 9a)	-	**539,451**	600,000
e-Health Project Funding	-	-	76,977
Behavioural Support Ontario (Note 9b)	-	**72,000**	-
French Language Health Service (Note 9c)	**296,800**	**296,800**	171,738
Francophone Community Engagement	-	-	118,681
Réseau du mieux-être francophone du Nord de l'Ontario (Note 9d)	**796,159**	**786,618**	229,040
Emergency Department Lead (Note 9e)	-	**72,000**	69,000
Critical Care Lead (Note 9f)	-	**72,000**	72,157
Aboriginal Engagement (Note 9g)	**100,000**	**100,000**	100,000
Aboriginal Health Transfer Fund		-	146,590
Emergency Room/Alternate Level of Care (Note 9h)	-	**100,000**	100,000
Primary Care Lead (Note 9i)	-	**18,000**	-
Amortization of capital assets	**60,676**	**60,678**	72,485
	1,311,778,062	**1,387,982,577**	1,341,003,128
Annual surplus and closing accumulated surplus	-	-	-

North East Local Health Integration Network

Statement of changes in net debt
year ended March 31, 2012

	2012	2011
	$	$
Annual surplus	-	-
Acquisition of tangible capital assets	-	(83,439)
Amortization of tangible capital assets	60,678	72,485
Increase in prepaid expenses	(16,853)	(678)
Decrease (increase) in net debt	43,825	(11,632)
Opening net debt	(226,822)	(215,190)
Closing net debt	(182,997)	(226,822)

North East Local Health Integration Network

Statement of cash flows
year ended March 31, 2012

	2012	2011
	$	$
Operating transactions		
Annual surplus	-	-
Items not affecting cash		
Amortization of capital assets	**60,678**	72,485
Amortization of deferred capital contributions (Note 4)	**(60,678)**	(72,485)
Changes in non-cash working capital		
Decrease in due from the LHIN Shared Service Office	**1,166**	3,337
Decrease (Increase) in accounts receivable	**51,288**	(67,719)
Decrease (Increase) in HST Receivable	**69,939**	(109,806)
Decrease (Increase) in due from MOHLTC-Health Service Providers	**12,705,062**	(16,584,656)
Decrease in due from MOHLTC-Other	-	235,000
Increase in prepaid expenses	**(16,853)**	(678)
Decrease in accounts payable and accrued liabilities	**(275,476)**	(8,149)
(Decrease) Increase in due to MOHLTC & eHealth Ontario	**(283,312)**	63,224
(Decrease) Increase in due to Health Service Providers	**(12,705,062)**	16,584,656
	(453,248)	115,209
Capital transaction		
Acquisition of capital assets	-	(83,439)
Financing transaction		
Increase in deferred capital contributions (Note 4)	-	83,439
Net (decrease) increase in cash	**(453,248)**	115,209
Cash, beginning of year	**813,944**	698,735
Cash, end of year	**360,696**	813,944

1. Description of business

The North East Local Health Integration Network was incorporated by Letters Patent on June 2, 2005 as a corporation without share capital. Following Royal Assent to Bill 36 on March 28, 2006, it was continued under the Local Health System Integration Act, 2006 (the "Act") as the North East Local Health Integration Network (the "LHIN") and its Letters Patent were extinguished. As an agent of the Crown, the LHIN is not subject to income taxation.

The LHIN is, and exercises its powers only as, an agent of the Crown. Limits on the LHIN's ability to undertake certain activities are set out in the Act.

The mandates of the LHIN are to plan, fund and integrate the local health system within its geographic area. The LHIN spans carefully defined geographical areas and allows for local communities and health care providers within the geographical area to work together to identify local priorities, plan health services and deliver them in a more coordinated fashion. The LHIN covers the area of Northeastern Ontario. The LHIN enters into service accountability agreements with service providers.

The LHIN is funded by the Province of Ontario in accordance with Ministry-LHIN Performance Agreement ("MLPA"), which describes budget arrangements established by the Ministry of Health and Long-Term Care ("MOHLTC") and provides the framework for the LHIN accountabilities and activities. These financial statements reflect agreed funding arrangements approved by the MOHLTC. The LHIN cannot authorize an amount in excess of the budget allocation set by the MOHLTC.

The LHIN assumed responsibility to authorize transfer payments to HSPs, effective April 1, 2007. The transfer payment amount is based on provisions associated with the respective HSP Accountability Agreement with the LHIN. Throughout the fiscal year, the LHIN authorizes and notifies the MOHLTC of the transfer payment amount; the MOHLTC, in turn, transfers the amount directly to the HSP. The cash associated with the transfer payment does not flow through the LHIN bank account. Commencing April 1, 2007, all funding payments to LHIN managed Health Service Providers ("HSP") in the LHIN geographic area, have flowed through the LHIN's financial statements. Funding allocations from the MOHLTC are reflected as revenue and an equal amount of transfer payments to authorized HSPs are expensed in the LHIN's financial statements for the year ended March 31, 2012.

The LHIN statements do not include any MOHLTC managed programs.

The LHIN is also funded by eHealth Ontario in accordance with the eHealth Ontario – LHIN Transfer Payment Agreement ("TPA"), which describes budget arrangements established by eHealth Ontario. These financial statements reflect agreed funding arrangements approved by eHealth Ontario. The LHIN cannot authorize an amount in excess of the budget allocation set by eHealth Ontario.

2. Significant accounting policies

The financial statements of the LHIN are the representations of management, prepared in accordance with Canadian generally accepted accounting principles for governments as established by the Public Sector Accounting Board ("PSAB") of the Canadian Institute of Chartered Accountants ("CICA") and, where applicable, the recommendations of the Accounting Standards Board ("AcSB") of the CICA as interpreted by the Province of Ontario. Significant accounting policies adopted by the LHIN are as follows:

Basis of accounting

Revenues and expenses are reported on the accrual basis of accounting. The accrual basis of accounting recognizes revenues in the fiscal year that the events giving rise to the revenues occur and they are earned and measurable; expenses are recognized in the fiscal year that the events giving rise to the expenses are incurred, resources are consumed, and they are measurable.

Through the accrual basis of accounting, expenses include non-cash items, such as the amortization of tangible assets and losses in the value of assets.

2. Significant accounting policies (continued)

Government transfer payments

Government transfer payments from the MOHLTC are recognized in the financial statements in the year in which the payment is authorized and the events giving rise to the transfer occur, performance criteria are met, and reasonable estimates of the amount can be made.

Certain amounts, including transfer payments from the MOHLTC, are received pursuant to legislation, regulation or agreement and may only be used in the conduct of certain programs or in the completion of specific work. Funding is only recognized as revenue in the fiscal year the related expenses are incurred or services performed. In addition, certain amounts received are used to pay expenses for which the related services have yet to be performed. These amounts are recorded as payable to the MOHLTC at period end.

Deferred capital contributions

Any amounts received that are used to fund expenditures that are recorded as tangible capital assets, are recorded as deferred capital contributions and are recognized as revenue over the useful life of the asset reflective of the provision of its services. The amount recorded under "revenue" in the statement of financial activities, is in accordance with the amortization policy applied to the related capital asset recorded.

Capital assets

Capital assets are recorded at historic cost. Historic cost includes the costs directly related to the acquisition, design, construction, development, improvement or betterment of capital assets. The cost of capital assets contributed is recorded at the estimated fair value on the date of contribution. Fair value of contributed tangible capital assets is estimated using the cost of asset or, where more appropriate, market or appraisal values. Where an estimate of fair value cannot be made, the tangible capital asset would be recognized at nominal value.

Maintenance and repair costs are recognized as an expense when incurred. Betterments or improvements that significantly increase or prolong the service life or capacity of a capital asset are capitalized.

Capital assets are stated at cost less accumulated amortization. Capital assets are amortized over their estimated useful lives as follows:

Furniture and fixtures	5 years straight-line method
Computer equipment	3 years straight-line method
Leasehold improvements	Life of lease straight-line method

For assets acquired and brought into use during the year, amortization is provided for a full year.

Segment disclosures

A segment is defined as a distinguishable activity or group of activities for which it is appropriate to separately report financial information. Management has determined that existing disclosures in the statement of financial activities and within the related notes for both the prior and current year sufficiently discloses information of all appropriate segments and therefore no additional disclosure is required.

Use of estimates

The preparation of financial statements in conformity with Canadian generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amount of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

3. Related party transactions

The LHIN Shared Services Office (the "LSSO") and the LHIN Collaborative (LHINC) are divisions of the Toronto Central LHIN and are subject to the same policies, guidelines and directives as the Toronto Central LHIN. The LSSO and LHINC, on behalf of the LHINs, are responsible for providing services to all LHINs. The full costs of providing these services are billed to all the LHINs. Any portions of the LSSO/LHINC operating costs overpaid (or not paid) by the LHIN at the year end are recorded as a receivable from (payable to) the LSSO/LHINC. This is all done pursuant to the agreement the LSSO/LHINC has with all the LHINs.

4. Deferred capital contributions

	2012	2011
	$	$
Balance, beginning of year	**226,144**	215,190
Capital contributions received	**-**	83,439
Amortization	**(60,678)**	(72,485)
Balance, end of year	**165,466**	226,144

5. Capital assets

			2012	2011
	Cost	Accumulated amortization	Net book value	Net book value
	$	$	$	$
Furniture and fixtures	**134,743**	**96,140**	**38,603**	51,471
Computer equipment	**96,622**	**96,622**	**-**	1,278
Leasehold improvements	**985,125**	**858,262**	**126,863**	173,395
	1,216,490	**1,051,024**	**165,466**	226,144

6. Budget figures

The budgets were approved by the Government of Ontario. The budget figures reported on the statement of financial activities reflect the initial budget at April 1, 2011. The figures have been reported for the purposes of these statements to comply with PSAB reporting principles. During the year the government approved budget adjustments. The following reflects the adjustments for the LHIN during the year:

The total HSP funding budget of $1,380,862,148 is made up of the following:

	$
Initial HSP Funding budget	**1,305,521,545**
Adjustment due to announcements made during the year	**75,340,603**
	1,380,862,148

The total operating budget of $7,168,405 is made up of the following:

Initial budget	**6,195,841**
Additional funding received during the year	**972,564**
Total budget	**7,168,405**
Amortization of deferred capital contributions	**60,678**
	1,388,091,231

7. Transfer payments to HSPs

The LHIN has authorization to allocate the funding of $1,380,862,148 to the various HSPs in its geographic area. The LHIN approved transfer payments to the various sectors as follows:

	2012	2011
	$	$
Operation of Hospitals	**931,799,098**	920,963,491
Grants to compensate for Municipal Taxation - Public Hospitals	**239,625**	231,975
Long Term Care Homes	**201,330,568**	182,523,879
Community Care Access Centres	**115,762,445**	106,197,563
Community Support Services	**25,759,201**	25,190,467
Acquired Brain Injury	**2,424,099**	2,170,491
Assisted Living Services in Supportive Housing	**14,043,889**	11,098,349
Community Health Centres	**16,736,495**	15,775,767
Community Mental Health	**51,687,216**	49,947,087
Substance Abuse & Gambling Problem	**21,079,512**	20,440,417
	1,380,862,148	1,334,539,486

The LHIN receives funding from the MOHLTC and eHealth Ontario and in turn allocates it to the HSPs. As at March 31, 2012, an amount of $7,992,935 (2011 - $20,697,997) was receivable from the MOHLTC and was payable to the HSPs. These amounts have been reflected as revenue and expenses in the statement of financial activities and are included in the table above.

8. General and administrative expenses

The statement of financial activities presents the expenses by function; the following classifies these same expenses by object:

	2012	2011
	$	$
Salaries and wages	**3,147,545**	2,671,788
HOOPP	**277,710**	252,040
Other benefits	**324,458**	279,041
Staff travel	**178,767**	190,375
Governance travel	**18,524**	55,156
Communications	**66,264**	93,224
Accommodation	**195,058**	171,625
Advertising	**46,969**	18,092
Banking	**-**	5
Consulting fees	**50,659**	67,270
Equipment rentals	**18,997**	16,085
Board Chair per diems	**21,375**	68,738
Other Governance per diems	**17,510**	29,532
Insurance	**16,337**	17,307
LHIN Shared Services Office	**382,525**	409,495
LHIN Collaborative	**26,971**	50,000
Other meeting expenses	**44,154**	36,987
Other governance expenses	**36,440**	40,991
Printing and translation	**55,895**	68,855
Staff development	**18,896**	20,778
IT equipment	**20,895**	40,544
Office supplies and equipment	**24,995**	59,254
Other	**11,938**	49,792
	5,002,882	4,706,974

9. a) e-Health expense

eHealth Ontario provided $600,000 to the LHIN. The LHIN has four permanent full-time staff to run a Project Management Office related to e-Health. In addition to covering the staff costs, the LHIN also incurred costs related to projects this group is responsible for. The total amount of expenses the LHIN incurred related to e-Health was $539,451.

b) Behavioural Support Ontario (BSO)

The LHIN received $72,000 from the Ministry of Health and Long-Term Care to support the BSO project to enhance health care for Ontarians with behaviours associated with complex and challenging mental health, dementia or other neurological conditions. The total amount of funds spent on this initiative was $72,000

c) French Language Health Services (FLHS)

The LHIN received $296,800 from the Ministry of Health and Long-Term care to support French Language Health Services programs. With these funds the LHIN employs three full-time staff to work on this file. In addition the funds were used to cover travel and other staff related costs. The total amount of expenses incurred related to FLHS was $296,800.

9. d) **Réseau du mieux-être francophone du Nord de l'Ontario**

The LHIN received $802,973 from the Ministry of Health and Long-Term Care to fund the operation of the Réseau du mieux-être francophone du Nord l'Ontario. Total funds flowed in 2011/12 were $786,618.

e) **Emergency Department Lead (ED Lead)**

The Ministry of Health and Long Term Care provided the LHIN $75,000 in one-time funding to pay the LHIN ED Lead $6,000 per month plus expenses, the LHIN contracted an area physician as the ED Lead; total monies paid out in 2011/12 are $72,000.

f) **Critical Care Lead (CC Lead)**

The Ministry of Health and Long Term Care provided the LHIN $75,000 in one-time funding to pay the LHIN CC Lead $6,000 per month plus expenses, the LHIN contracted an area physician as the CC Lead; total monies paid out in 2011/12 are $72,000.

g) **Aboriginal Engagement**

The Ministry of Health and Long Term Care provided an additional $100,000 in base funding for the purposes of engaging the Aboriginal population and organizations within the North East LHIN. The total amount of expenses paid using this funding was $100,000.

h) **Emergency Room/Alternate Level of Care**

The Ministry of Health and Long Term Care provided $100,000 in one-time funding to help the LHIN in supporting the North East ER/ALC Performance Lead, this amount was spent in full.

i) **Primary Care Lead (PC Lead)**

The Ministry of Health and Long Term Care provided the LHIN $43,750 in one-time funding to pay the LHIN PC Lead $6,000 per month plus expenses to support the Primary Care LHIN Lead Pilot Program. The LHIN contracted an area physician as the PC Lead; total monies paid out in 2011/12 are $18,000.

10. Funding repayable to the MOHLTC and eHealth Ontario

In accordance with the MLPA, the LHIN is required to be in a balanced position at year end. Thus, any funding received in excess of expenses incurred, is required to be returned to the MOHLTC.

In accordance with the TPA, the LHIN is required to be in a balanced position at year-end. Thus, any funding received in excess of expense incurred, is required to be returned to eHealth Ontario.

a. The amount repayable to the MOHLTC is made up of the following components:

	Funding received	Eligible expenses	Excess funding
	$	$	$
Transfer payments to HSPs	1,380,862,148	1,380,862,148	-
LHIN operations	5,002,882	5,002,882	-
Amortization of capital assets	60,678	60,678	-
E-Health	600,000	539,451	60,549
Behavioural Support Ontario	72,000	72,000	-
French Language Health Service	296,800	296,800	-
Réseau du mieux-être francophone du Nord l'Ontario	802,973	786,618	16,355
Emergency Department Lead	75,000	72,000	3,000
Critical Care Lead	75,000	72,000	3,000
Aboriginal Engagement	100,000	100,000	-
Emergency Room/Alternate Level of Care	100,000	100,000	-
Primary Care Lead	43,750	18,000	25,750
	1,388,091,231	1,387,982,577	108,654

b. The amount due to the MOHLTC is made up of the following components:

	2012	2011
	$	$
Opening balance	360,216	296,992
In-Year funds repayable to MOHLTC	31,750	14,500
Funding recovered by the MOHLTC	(391,966)	(164,902)
Funding allowed to be carried into 2011	-	(146,590)
Funding repayable to the MOHLTC (Note 10A)	16,355	360,216
Closing balance	16,355	360,216

c. The amount due to eHealth Ontario is made up of the following components:

	2012	2011
	$	$
Opening balance	-	-
In-Year funds repayable to eHealth Ontario	-	-
Funding recovered by eHealth Ontario	-	-
Funding repayable to the eHealth Ontario (Note 10A)	60,549	-
Closing balance	60,549	-

11. Pension agreements

The LHIN makes contributions to the Healthcare of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of approximately 39 members of its staff. The plan is a defined benefit plan, which specifies the amount of retirement benefit to be received by the employees, based on the length of service and rates of pay. The amount contributed to HOOPP for fiscal 2012 was $348,703 (2011 - $312,327) for current service costs and is included as an expense in the statement of financial activities. The last actuarial valuation was completed for the plan as at December 31, 2011. At that time the plan was fully funded.

12. Guarantees

The LHIN is subject to the provisions of the *Financial Administration Act*. As a result, in the normal course of business, the LHIN may not enter into agreements that include indemnities in the favor of third parties, except in accordance with the *Financial Administration Act* and the related Indemnification Directive.

An indemnity of the Chief Executive Officer was provided directly by the LHIN pursuant to the terms of the *Local Health System Integration Act, 2006* and in accordance with s. 28 of the *Financial Administration Act*.

13. Commitments

The LHIN has commitments under various operating leases related to building and equipment extending to 2016. Minimum lease payments due in each of the next four years are as follows:

	$
2013	218,289
2014	205,680
2015	160,786
2016	40,197

The LHIN also has funding commitments to HSPs associated with accountability agreements. As of March 31, 2012 the LHIN had signed Accountability Agreements with all Hospitals for the next year and Community Agencies for the next two years. The actual amounts which will ultimately be paid are contingent upon actual LHIN funding received from MOHLTC.